HISTORY FORM

DATE: _____

NAME: _____ AGE: _____ BIRTHDATE: _____

ADDRESS: _____ SEX: ☐ M ☐ F

_____ HOME #: _____

_____ WORK #: _____

OCCUPATION: _____ EMERGENCY CONTACT: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated EMERGENCY CONTACT #: _____

Describe what symptoms bother you most?

_____

_____

When did your condition begin?

What medication have you tried?

_____

Does it help? _____

Has any family member (parents, siblings) had: (please include mother, father, sister, brother)

Allergies _____

Asthma _____

Emphysema _____

Cancer _____

Hypertension _____

Heart Disease _____

Other (list specific disease) _____

Have you ever been allergy tested? ☐Yes ☐ No

Results: _____

Have you had Radiology tests of your Nose or Chest?

_____

Drug Allergy (describe)

_____

Food Allergy

_____

Are you taking medication for other medical condition? ☐Yes ☐ No

Condition/ Medication? _____

_____

_____

_____

_____

_____

Do you think your occupation has anything to do with your symptoms? ☐Yes ☐ No

Describe your occupation: _____

_____

Smoker in the home? ☐Yes ☐ No

Do you smoke? ☐Yes ☐ No

Cigarettes #_____ day

Years Smoked _____

Do you have animals in your home? How Many?

Cat: _____

Dog: _____

Other: _____

Do you drink Alcohol? ☐Yes ☐ No

How much per week? _____

Past Medical History & Review of Symptoms:
(Please Circle if you had problems with or are currently complaining of any of the following)

1. High Blood Pressure	11. Rheumatic Fever	21. Vomiting	31. Hepatitis or Jaundice	41. Blood Disorder
2. Diabetes	12. Asthma	22. Constipation	32. Thyroid Disease	42. Venereal Disease
3. Cancer	13. Bronchitis	23. Diarrhea	33. Head or Neck radiation	43. Anxiety
4. Heart Disease	14. Pneumonia	24. Blood in Stool	34. Headache	44. Depression
5. Chest Pain/ Tightness	15. Persistent Cough	25. Ulcers	35. Kidney Disease	45. Anemia
6. Shortness of Breath	16. T.B.	26. Change in Bowel Habits	36. Kidney Stones	46. Alcohol Abuse
7. Swollen Ankles	17. Hay Fever	27. Unexplained weight gain/loss	37. Difficulty Urinating	47. Drug Abuse
8. Palpitations	18. Abdominal Discomfort	28. Hemorrhoids	38. Arthritis	48. Gout
9. Lightheadedness	19. Indigestion	29. Gall Bladder Disease	39. Low Back Problems	49. _____
10. Frequent Urination	20. Nausea	30. Colitis	40. Skin Disease	50. _____

Section for ***WOMEN*** Only:

Did you miss your menstrual cycle? Yes No

Do you use Birth control? Yes No

Are you Pregnant? Yes No

If yes, how many weeks pregnant are you? _____

Section for ***PARENTS FOR CHILDREN*** (Under/ Less than 12 years old)

1. Was your child born vaginal or c-section? _____
2. What was his/ her weight at birth? _____
3. Were they born prematurely? _____
4. Did your child have Eczema (rash on face or body)? _____

_____
MD Reviewed

MITCHELL MEDICAL GROUP OF NEW YORK, P.C.

Immunology, Alternative and Integrative Medicine

57 West 57th Street, #601
New York, NY 10019

165 North Village Ave., #129
Rockville Centre, NY 11570

Date:_____

PATIENT'S NAME: (Last)_____(First)_____

ADDRESS: (Home)_____

CITY & STATE:_____**ZIP CODE:**_____

SEX: ( ) **M** ( ) **F** **AGE:**_____**BIRTHDATE:**_____**SSN:**_____

PHONE: (Business)_____(Home)_____

CELL PHONE NUMBER:_____

E-MAIL ADDRESS:_____

COMPANY NAME:_____

ADDRESS:_____**OCCUPATION:**_____

CITY & STATE:_____**ZIP CODE:**_____

REASON FOR BEING HERE:_____

HAVE YOU BEEN HERE BEFORE:_____

HOW DID YOU FIND OUT ABOUT OUR PRACTICE:_____

ARE YOU ALLERGIC TO ANY MEDICATION:_____

CURRENT MEDICATION:_____

NAME OF INSURANCE CARRIER:_____

NAME OF POLICY HOLDER:_____**ID#:**_____

POLICY HOLDER'S DATE OF BIRTH:_____**SSN:**_____

ARE YOU OR YOUR SPOUSE COVERED BY ANY OTHER MEDICAL INSURANCE_____**YES**_____**NO**

IF YES, PLEASE GIVE INSURANCE CARRIER AND POLICY NUMBER:_____

_____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED:_____

_____

To the best of my knowledge, the insurance information I have provided is correct. If for any reason, my visit or medical procedure deemed necessary by my physician is denied or if my insurance is not valid, I agree to be fully responsible for the fees and services rendered to me. If I provide any wrong information or if my bill goes to collection, I will be responsible for my bill in its entirety and any collection fees.

ALSO I HAVE REVIEWED AND SEEN THE PRACTICE'S PRIVACY NOTICE

PATIENT'S OR GUARDIAN'S SIGNATURE: _____

MITCHELL MEDICAL GROUP OF NEW YORK, P.C.

PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION &
WRITTEN RECEPIT OF NOTICE OF PRIVACY PRACTICES

I hereby give my consent for Mitchell Medical Group of NY, P.C. to use and disclose Protected Health Information (PHI) about me to carry out **Treatment, Payment and Healthcare Operations (TPO).** Mitchell Medical Group of NY, P.C.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Mitchell Medical Group of NY, P.C. reserves the right to change Notice of Privacy Practices at anytime. A revised Notice of Privacy may be obtained by forwarding a written request to Mitchell Medical Group of NY, P.C., Privacy Officer at 165 N. Village Ave., #129 Rockville Center, NY 11570 or 57 West 57th Street, #601 New York, NY 10019

PLEASE CROSS OFF EACH ITEM BELOW THAT YOU DO NOT WANT TO ALLOW US TO DO! (If any one is a no, then whole number is out)!

With this consent Mitchell Medical Group of NY, P.C. may:

1) Call my home or cell phone and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory & biopsy results among others.
2) At any alternative location, the practice will only leave a message on my personal voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory & biopsy results among others. **However, at any alternative location call Mitchell Medical Group of NY will not leave a message about my medical condition or lab results with any person.**
3) May mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements.
4) May e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements and practice updates.

I have the right to request that Mitchell Medical Group of NY, P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Mitchell Medical Group of NY, P.C.'s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Mitchell Medical Group of NY, P.C. may decline to provide treatment to me.

I have received a copy of Mitchell Medical Group of NY, P.C.'s Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Guardian | Print Name of Patient's Legal Guardian

_____ _____

Patient's Name | Date

MITCHELL MEDICAL GROUP OF NEW YORK, P.C.
Immunology, Alternative and Integrative Medicine

57 West 57th Street, #601
New York, NY 10019
Tele: 212-586-7400

165 North Village Ave., #129
Rockville Centre, NY 11570
Tele: 516-678-9600

Prescription Form

Patient Name: _____

DOB: _____

By signing this prescription form, I request and authorize the shipment of my compounded medication to office's of Mitchell Medical Group of New York, P.C..

_____
Patient Signature

_____
Date

MITCHELL MEDICAL GROUP OF NEW YORK, P.C.
Immunology, Alternative and Integrative Medicine

165 N. VILLAGE AVE, #129
ROCKVILLE CENTRE, NY 11570
TELE: 516/678-9600
FAX: 516/678-9618

57 WEST 57th STREET, #601
NEW YORK, NY 10019
212/586-7400
212/586-6880

ADVANCED BENEFICIARY NOTICE

I, _____, have been made aware by the staff at Mitchell Medical Group of New York, P.C. that I may not be reimbursed for medical services rendered to me.

I fully understand that any procedure not covered by my insurance is my responsibility.

_____
Patient Name

_____
Date

MITCHELL MEDICAL GROUP OF NEW YORK, P.C.
Immunology, Alternative and Integrative Medicine

57 West 57th Street, #601
New York, NY 10019

165 North Village Ave., #129
Rockville Centre, NY 11570

DUE TO EXCESSIVE CANCELLATIONS AND

NO SHOWS, WE WILL BE REQUIRING ALL PATIENTS

TO CANCEL WITHIN

48 HOURS INSTEAD OF 24 HOURS.

IF A PATIENT CANCELS OR DOES NOT SHOW,

THEY WILL BE CHARGED FOR THEIR VISIT.

WE NEED TO BE ABLE TO ACCOMMODATE O

THER PATIENTS WHO WISH TO COME IN.

WE ARE SORRY FOR ANY INCONVENIENCE.

_____
Signature of Patient or Legal Guardian

_____
Signature of Patient or Legal Guardian

_____
Patient Name

_____
Date